Long-term Care Infrastructure Project; Third Party Administration
Responses to Vendor Questions
6/22/09

General questions

Question 1:

What are the expected claims per participant per month for each program?

Response:
On average, the Family Care and Family Care Partnership programs process approximately 10 to 13 claims per member per month. Because children's waiver programs currently accept monthly summary data, the actual volume cannot be determined. We would expect that volume to be similar to the other programs.

Question 2:

Contract Terms (page 12) states that the contract will run for five years. The Cost Proposal Form (page 150) requests costing on a per member per month basis. Is the State expecting the per member per month cost proposed to be good for all five years, or is the state expecting to have a separate and unique per member per month for each of the five years?

Response:
Due to current state fiscal circumstances, the Department would prefer to hold this cost constant throughout the term of the contract however; as stated in section 7.2 (page 57), "the cost proposal must identify any anticipated increases or discounts (e.g., volume pricing, pricing of electronic vs. paper volume)".

Question 3:

Can MCOs opt in at any time during the next five years? Are they limited to opting in only at the beginning of a plan year or can they opt in at anytime during the plan year? How much lead time is the MCO required to give the TPA vendor when they opt in?

Response:
MCOs may begin operations under this procurement at any time during the five year term. Individual contracts between MCOs and the TPA will govern the conditions of transition. The Department will establish guidelines concerning transition lead times in collaboration with the selected vendor.

Question 4:

Are billing and collections limited to claims receivables and member share transactions, or are there additional billing and collection requirements (please specify detailed requirements)?

Response:
The TPA is expected to handle all transactions related to claims processing, and also handle member share transactions that include collection of cost share, room and board, spend down, and voluntary contributions. Detailed

requirements will be specified in the individual contracts with MCOs or the Department.

Question 5:

The State lists core business requirements. Can a submitter propose alternative requirements if it can be demonstrated that the alternative approach and requirements meet the underlying concern of the State, but in a manner that will provide greater value to the program (greater value in the sense of lower costs or increased customer satisfaction)?

Response:

The "core" business requirements specified in this RFP are intended to illustrate the set of requirements that are common to all programs/benefit packages within the scope of this RFP. The requirements listed in this document are intended to be specific regarding their deliverables; however, the vendor approaches to meet the requirements should provide the most efficient and cost-effective solutions available.

Question 6:

In the pricing instructions for "Organization Level Contracting", in the sentence "Time and expenses will not exceed current state vendor limits", please explain whether expenses are mileage, hotel, and other travel related limits and further explain state vendor limits related to "time".

Response:

The statement "time and expenses will not exceed current state vendor limits" is intended to limit the costs for time and expenses to current state agreements. Cost limits for contracted time can be found on VendorNet at http://vendornet.state.wi.us. The limits for expenses can be found on the DHS web site at: http://dhs.wisconsin.gov/bfs/appa/travel.htm.

Questions related to specific requirements

4.1.1 Provide 24 x 7 access to all contract-related documents maintained by the TPA.

Question:

Which documents are being referenced here? Between the State and TPA? Between the MCOs and TPA? Providers/Facilities and TPA? Any or all? Who should have 24 x7 access? The State or MCOs? Only the TPA staff?

Response:

All documents that are being stored by the TPA to support claims processing and other contracted services under this procurement must be available 24 x 7.

Full access should be made available to MCOs, the Department, and any operational agencies under contract with the Department for these programs. Limited access should also be available to providers, based on terms specified in negotiated contracts.

4.2.10 Deduct either the provider reported or recipient liability amounts from claims, track remaining balances, and provide the capability to invoice recipients for the remaining monthly amount due, as directed by the contracting organization. Maintain the service charge data for encounter reporting.

Question:
Please clarify the term “service charge”.

Response:
This means the cost-related data for the service (e.g., allowed amount, billed amount, paid amounts).

4.2.30 Maintain all third party resource information at the recipient-specific level including, but not limited to:

- Carrier name and identifier.
- Policy number and group number.
- Effective date of coverage and end date of coverage, if applicable.
- Add date, change date and verification date of insurance.
- Source of the insurance information identifier.
- Type of verification of insurance identifier.
- Policy holder name, address, SSN, date of birth, relationship to insured, employer name and address.
- Specific information on types of services covered by the policy, as defined by the contracting organization.
- Part A and/or Part B Medicare.
- Medicare Managed Care plan.
- Medicare Supplemental plan.
- Drug Plan.
- Tricare.

Question:
Is the Tricare information in a unique data format from the other examples listed?

Response:
It is not expected that Tricare information will be significantly different than any other third party information.

4.2.79 Establish claims control balancing processes.

Question:
Please clarify this item, perhaps with an example.

Response:
It is expected that the TPA will control claims and inquiry receipts, manage inventories, and have processes in place to ensure the proper handling of all contract inventory items. For example, claims counts in each stage of handling should reconcile to the total claims inventory at all times.

4.2.111 Meet all paper claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows:

- Ninety percent (90%) of all claims shall be processed within ten (10) calendar days of receipt.
- Ninety-five percent (95%) of all claims shall be processed within twenty-one (21) calendar days of receipt.
- Ninety-nine percent (99%) of all claims shall be processed within thirty (30) calendar days of receipt.
- One hundred percent (100%) of all claims shall be processed within ninety (90) calendar days of receipt.

Question:
Do these standards apply to all claims, or just clean claims? Which state and federal standards are being referenced with the timelines stated?

Response:
This applies to all claims. This requirement specifies current expectations for processing timelines. Future contract terms may change based on state and federal requirements, and will be published when they are established. Any additional standards will be subject to contract terms negotiated between the Department and the vendor.

4.2.113 Meet all electronic claims and adjustment processing standards set by the state or the federal government. These standards include processing claims as follows:

- Ninety percent (90%) of all claims shall be processed within five (5) calendar days of receipt.
- Ninety-five percent (95%) of all claims shall be processed within ten (10) calendar days of receipt.
- Ninety-nine percent (99%) of all claims shall be processed within fifteen (15) calendar days of receipt.
- One hundred percent (100%) of all claims shall be processed within twenty (20) calendar days of receipt.

Question:
Please define electronic claims – does this item refer to claims coming from clearinghouses, EDI feeds, web portals, other means? Do these standards apply to all claims, or just clean claims? Which state and federal standards are being referenced with the timelines stated?

Response:
Electronic claims may come from a variety of sources, not limited to those stated here. Other electronic forms may include provider submission using e-mail, for example.

As stated in the response to the previous question, this requirement applies to all claims. Current expectations are stated in the requirement, and future state and federal requirements will be published when they are established. Any additional standards will be subject to contract terms negotiated between the Department and the vendor.

Question:
This requirement states “calendar days”; should it instead state “business days?”

Response:
The requirement correctly states calendar days.

4.2.117 Maintain pricing data based on:
- Fee schedules by benefit package.
- Provider-specific usual and customary charges.
- Procedure modifiers (e.g., DME).
- Per diem rates.
- Self-directed support services by budget or dollar limit.
- DRGs.
- Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaging allowance).
- MAC, EAC, AWP, AWP- ten percent (10%), and direct pricing for drugs.
- Case-mix rates for LTC (in addition to facility-specific per diem rates by level of care).

Question:
Please clarify the phrase “case-mix rate”.

Response:
“Case-mix rates” refer to pricing based on characteristics of the member population. For example, MCOs or facilities may have multiple rates based on the case mix, or have a pricing adjustment based on a complex mix of cases. Detailed requirements will be specified in the individual contracts with MCOs or the Department.

4.2.120 Accommodate retroactive changes, future changes, and expanded pricing processes with no additional cost.

Question:
“Accommodating retroactive changes, future changes, and expanded pricing processes with no additional cost” seems open ended. Is this referring to just pricing or fee issues, or all claim processing scenarios in general?

Response:
This includes retroactive changes to any data required to adjudicate claims (e.g., eligibility dates, pricing agreements, pre-authorizations).

4.2.121 Continue claims processing services for 180 days after termination date for dates of service prior to the termination date at no additional cost. During and at the end of the termination run-out period, the contractor will fully cooperate in the transfer of all records and reports, including computer records and other data as requested by contracting organization within 10 business days of the request, at no additional cost.

Question:

Would the TPA's normal PMPM fee be applicable during the 180 day period, just no additional costs on top of that, or is the state requesting no fees at all during the 180 day period?

Response:
The PMPM is expected to handle claims incurred during the month for which it is paid. If those claims are submitted after the termination date of the contract, it is assumed the vendor has already been paid for the claims incurred during the month for which PMPM was paid. The Department does not expect to incur any additional costs for processing those claims during the run-out period of 180 days.

4.4.27 Maintain multiple receivable accounts by payer.

Question:
What entities are the Payers in this example? MCOs? Providers? Insurance companies?

Response:
Payers are intended to be MCOs or children's waiver agencies.

4.4.30 Provide the ability to link post payment recovery to the original claim.

Question:
Please clarify this item with some further description or an example if possible.

Response:
Any refunds or adjustments to paid claims, received after payment of the original claim, must be tied to the original claim from a data perspective. For example, a third party insurance claim was paid to the provider for a claim that has already been paid by the TPA. The provider refunds the overpayment to the TPA. The TPA creates a credit to the claims records for the refunded amount, which must be tied to the original claim for audit and analysis purposes.

4.5.5 Maintain recipient eligibility status including enrollments and disenrollments, including dates and reasons. There may be multiple entries for one recipient.

Question:
Can a person have benefits in multiple programs under one MCO? If so, is the same identifier used for a participant in multiple programs under the same MCO?

Response:
No, a member is only enrolled in one managed care program at one MCO. Eligibility status may change throughout any given period of time, which could result in multiple eligibility status entries for one recipient, but the member ID would remain the same.

4.5.6 Produce reports on enrollments and disenrollments, as specified by the contracting organization.

Question:
What type of eligibility information (i.e., dates, MCO's Identification number, etc.) is expected to be included in files or reports sent out by the TPA vendor?

Response:
The content of reports will be specified by the contracting organization, but is likely to include, but is not limited to, information on member, eligibility dates, eligibility status, MCO information, enrollment dates, disenrollment dates, and possibly disenrollment (or loss of eligibility) reasons.

4.5.8 Provide enrollment reports calculating enrollment days for programs which enroll on the eligibility date, versus the first of the month.

Question:
What type of eligibility information (i.e., dates, MCO's Identification number, etc.) is expected to be included in files or reports sent out by the TPA vendor?

Response:
See response to 4.5.6 question above.

4.5.10 Create and maintain a unique recipient identification number for each recipient with capability to store identification numbers that are up to fourteen (14) characters in history, as directed by the contracting organization agreements.

Question:
Is the “unique recipient identification number” at the MCO level or at the program level? If at program level, will there be multiple identifiers for a member enrolled in multiple programs? (This question also applies to 4.5.11 and 4.5.14.)

Response:
Identification numbers are assigned at the recipient level and are unique to the person, regardless of MCO or managed care program.

4.5.11 Maintain current and historical recipient names and assigned identification numbers, and provide an automated link to claims for the recipient under current and historical names and identification numbers.

Question:
Is the “unique recipient identification number” at the MCO level or at the program level? If at program level, will there be multiple identifiers for a member enrolled in multiple programs? (This question also applies to 4.5.10, and 4.5.14.)

Response:
See response to 4.5.10 question above.

4.5.13 Accept recipient eligibility and provide secure update capability to designated contracting organization staff.

Question:

Can a person have benefits in multiple programs under one MCO? If so, is the same identifier used for a participant in multiple programs under the same MCO?

Response:
See response to 4.5.5 question above.

4.5.14 Provide the ability to issue ID cards and enrollment information packets to members/participants including the ability to reflect multiple eligibility dates for Medicare integrated program members, tracking multiple identification numbers accordingly.

Question:
Is the "unique recipient identification number" at the MCO level or at the program level? If at program level, will there be multiple identifiers for a member enrolled in multiple programs? (This question also applies to 4.5.10, and 4.5.11.)

Response:
See response to 4.5.10 question above.

4.6.4 Provide the ability to match claims to specific pre-authorized services (not just to a pre-authorization identification number), matching and decrementing pre-authorizations based on provider encounter specific data.

Question:
In reference to "match claims to specific pre-authorized services" does this mean match for reporting purposes and/or during the real-time processing of claims? What data elements, other than authorization number, are required to be matched?

Response:
Claims must be matched to pre-authorizations for correct adjudication and for reporting. Relative to matching claims to pre-authorizations for adjudication, it is expected that the claims will be matched by member, provider, and service information (including dates of services, procedure codes, etc.).

4.6.17 Accommodate atypical claim forms used for self directed supports services authorizations and recipient approval or verification of services.

Question:
Is the interaction for this item between the TPA and Recipient, or some intermediary, such as a fiscal agent?

Response:
Claims for self-directed supports may come from the provider, the recipient, or a fiscal agent.

4.7.25 Allow providers the ability to maintain their own provider demographic information.

Question:

Which specific demographic information should be accessible and modifiable by the providers? Name, address, tax id, etc.? Please be as specific as possible.

Response:
The demographic information that can be changed by providers will be specified by the contracting organization. It is not expected that providers would be able to change key identification data however; it may be negotiated to allow them to update contact information and location information.

4.8.1 Track grievances and complaints in an established tracking system through referral to the contracting organization, and following resolution direction from the contracting organization.

Question:
Is the tracking of grievances and complaints related ONLY to claims processing/payment activities, or ALL MCO issues in general?

Response:
It is expected that the TPA will only track grievances and complaints related to claims processing, related to payment activities, and regarding any other service related issues within the scope of their contract (e.g., customer service complaints).

5.4.1 Produce risk adjustment data submissions for CMS, as directed by the MCO.

Question:
Please explain the phrase “risk adjustment data” or provide an example.

Response:
This includes reporting requirements specified by CMS for Risk Adjustment Processing System (RAPS) participation. See the CMS web site or this web site for additional information regarding RAPS: http://www.csscoperations.com/